

MEDICAL ASSISTANCE  
MANAGED CARE  
PROVIDER CHANGE FORM

Please complete this Change Form and mail to:

(You may also take this form to your local Department of Social Services Office and they can mail it for you).

Medical Services  
700 Governor’s Dr  
Pierre, SD 57501

SECTION 1 – REASON FOR CHANGING YOUR PCP

When requesting a change in your Primary Care Provider selection please state your main reason for requesting a change.

- Long waiting periods to see the Doctor
- Not being referred (authorized) to specialists when medically necessary
- Doctor (or on-call staff) not available 24 hours a day, 7 days a week
- Dissatisfaction with PCP
- PCP not accepting new patients
- Moved to new area
- Other

NOTE: IF YOUR CHANGE REQUEST IS APPROVED, YOUR NEW PCP DOES NOT TAKE EFFECT IMMEDIATELY. CHANGE APPROVALS ARE EFFECTIVE ON THE FIRST DAY OF THE MONTH AFTER APPROVAL.

SECTION 2 – NEW PRIMARY CARE PROVIDER(S)

	MANAGED CARE RECIPIENT’S NAME (Family members eligible for Medical Assistance)	RECIPIENT ID NUMBER (from notice or ID card)	PRIMARY CARE PROVIDER NAME (from Provider list)	PCP CODE (from Provider list)
0				
1				
2				
3				
4				
5				
6				
7				
8				
9				

I understand the Medical Assistance Managed Care Program rules and requirements and also understand that by not following those rules and requirements I may be responsible for payment of medical bills. Refer to the Medical Assistance Program Recipient Handbook for more information.

Your Name

Telephone Number

Signature

Date